

# Spouse or Qualified Domestic Partner Certification

Complete and return the form(s) in this packet if you want to:

- Add a spouse to your Public Employees Benefits Board (PEBB) coverage, or
- Add a qualified domestic partner to your PEBB coverage.

## Adding a Spouse

Remove the *Declaration of Marriage or Qualified Domestic Partnership* form.

### Step One:

- Complete Section 1.

### Step Two:

- Read and complete Section 3.

### Step Three:

- **Employees:** Return the form to your personnel, payroll, or benefits office.
- **All others:** Return the form to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

## Adding a Qualified Domestic Partner

To add a domestic partner, you may either:

- Complete and return the form(s) in this packet; OR
- **If your same-sex domestic partnership is registered with the Washington Secretary of State's Office:** Send a copy of your Certificate of State Registered Domestic Partnership or registration card as instructed in Step Four below. You must also complete and return the enclosed *Declaration of Tax Status* form. (See Step Two.)

### Step One:

- Remove the *Declaration of Marriage or Qualified Domestic Partnership* form. Review and complete Section 2; be sure you meet the five criteria.
- Read and complete Section 3.

### Step Two:

- Review the *Declaration of Tax Status* on the back of the form.
- Determine whether your qualified domestic partner fulfills the three requirements listed for Internal Revenue Code (IRC) Section 152 tax eligibility. **Your domestic partner does not need to qualify as an IRC Section 152 dependent to qualify for PEBB coverage.**
- Print your names at the top of the *Declaration of Tax Status* form.
- If you are unsure whether your domestic partner qualifies as an IRC Section 152 dependent, you may confirm eligibility by using the *IRC Worksheet for Determining Dependent Status* form. (See Step Three.)
- Sign, date, and print your social security number on the *Declaration of Tax Status* form.
- If your domestic partner qualifies as an IRC Section 152 dependent, go to Step Four.

### Step Three:

- If completing the optional *Worksheet for Determining Dependent Status*, you and your qualified domestic partner will need to know your:
  - Gross monthly income
  - Mortgage/rental payment
  - Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- Keep the worksheet for your personal tax records. You do not need to return the worksheet with the other forms.

### Step Four:

- **Employees:** Return the forms to your personnel, payroll, or benefits office.
- **All others:** Return the forms to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

**Important:**  
Be sure to also  
submit a completed  
PEBB enrollment  
form.

# Worksheet for Determining Dependent Status

This worksheet is modeled on the worksheet in IRS Publication 17 and requests historical information. However, it is necessary that you determine whether your domestic partner will qualify as a dependent for the calendar year the dependent is enrolling (the "enrollment year"). Complete this worksheet using the income and expenses you anticipate during the enrollment year.

## Important

You can use this worksheet to determine whether your qualified domestic partner and/or his or her child(ren) also qualify as dependents under Internal Revenue Code (IRC) Section 152 (in general, he or she must receive more than half of his or her support from you).

## Income

1. Did the domestic partner you supported receive any income such as wages, interest dividends, pensions, rents, social security, or welfare?  
☐ Yes (Answer questions 2, 3, 4, and 5.)  
☐ No (Skip to question 6.)
2. Total annual income received \$ \_\_\_\_\_
3. Amount of income used for your domestic partner's support \$ \_\_\_\_\_
4. Amount of income used for purposes other than support \$ \_\_\_\_\_
5. Amount of income either saved or not used for lines 3 or 4 \$ \_\_\_\_\_

**The total of lines 3, 4, and 5 should equal line 2.**

## Yearly household expenses where you and your domestic partner lived

6. Lodging (*Complete either a or b*):
  - a. Rent paid \$ \_\_\_\_\_
  - b. If not rented, show fair rental value of your home \$ \_\_\_\_\_
 If your domestic partner owned the home, include this amount on line 20.
7. Food \$ \_\_\_\_\_
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) \$ \_\_\_\_\_
9. Repairs that were not included in line 6a or 6b \$ \_\_\_\_\_
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). \$ \_\_\_\_\_
11. Add lines 6a or 6b through 10 \$ \_\_\_\_\_
12. Total number of persons who lived in household \$ \_\_\_\_\_

## Yearly expenses for your domestic partner

13. Divide line 11 by line 12 to determine each person's part of household expenses  

$$\text{\$ } \frac{\text{line 11}}{\text{line 12}} = \text{\$ } \text{line 13}$$
14. Clothing \$ \_\_\_\_\_
15. Education \$ \_\_\_\_\_
16. Medical and dental expenses not paid for or reimbursed by insurance \$ \_\_\_\_\_
17. Travel and recreation \$ \_\_\_\_\_
18. Other (please specify) \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_
19. Total amount for your domestic partner's yearly support (Add lines 13 through 18.) \$ \_\_\_\_\_

20. Amount your **domestic partner** provided for his or her own support  
Line 3 \$ \_\_\_\_\_  
Line 6b (include if your domestic partner owned the home) \$ \_\_\_\_\_  
**Add lines 3 and 6b, if each are applicable** \$ \_\_\_\_\_  
line 20

21. Amount that others added to your domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 2. \$ \_\_\_\_\_

22. Amount **you** provided for your domestic partner's support:  
\$ \_\_\_\_\_ + \$ \_\_\_\_\_ - \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
line 20 line 21 line 19 line 22

23. 50% of line 19 \$ \_\_\_\_\_

If line 22 is more than line 23, your domestic partner qualifies as an IRC Section 152 dependent. Check "Yes" on the *Declaration of Tax Status* form.

If line 22 is **not** more than line 23, check "No" on the *Declaration of Tax Status* form and consult with your payroll office regarding changes to your taxable income. As a result, the amount **your employer will contribute** for your qualified domestic partner and/or child(ren) is considered taxable by the IRS.

**State and higher-education employees:** The tables below show the amount that will be added to your total gross income and calculated into your withholding tax. This will be reflected on your pay stub, as well as your *Wage and Tax Statement* (your W-2). The monthly amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

**Employees of K-12 school districts, educational service districts (ESDs), and local government employer groups** (cities, counties, municipalities, ports, water districts, etc.): Contact your payroll office for employer contribution amounts.

## Active state and higher-education employees

2009 State Contribution for Medical and Dental Coverage for:			
Medical Plan	Partner	Partner's Child(ren)	Partner and Child(ren)
All medical plans	\$427	\$338	\$765
2009 State Contribution for Dental Coverage (Without Medical Coverage) for:			
Dental Plan	Partner	Partner's Child(ren)	Partner and Child(ren)
All dental plans	\$42	\$42	\$84

**Retirees** who cover a Medicare-enrolled qualified domestic partner will receive a 1099 form from the HCA reflecting the state's contribution toward the domestic partner's medical coverage for the year. The amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

## Medicare retirees

Medical Plan	2009 State Contribution for Medical Coverage for Partner
Aetna Public Employees Plan	\$183
Group Health Classic	136
Group Health Value	121
Kaiser Permanente Classic	165
Kaiser Permanente Value	133
Medicare Supplement Plan E Retired	66
Medicare Supplement Plan E Disabled	112
Medicare Supplement Plan J Retired with Rx	135
Medicare Supplement Plan J Disabled with Rx	183
Medicare Supplement Plan J Retired without Rx	96
Medicare Supplement Plan J Disabled without Rx	162
Secure Horizons Classic	180
Secure Horizons Value	138
Uniform Medical Plan	164

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

# Declaration of Marriage or Qualified Domestic Partnership



## Section 1: Spouse

I, \_\_\_\_\_, certify that \_\_\_\_\_  
Print Subscriber's Name Print Spouse's Name  
and I were legally married on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
month day year

## Section 2: Domestic partner

I, \_\_\_\_\_, certify that \_\_\_\_\_  
Print Subscriber's Name Print Qualified Domestic Partner's Name  
and I established a domestic partnership beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and we meet the following  
month day year  
criteria for a domestic partnership:

1. We have a close personal relationship in lieu of a lawful marriage.
2. We are not married to anyone.
3. We are each other's sole domestic partner and are responsible for each other's common welfare.
4. We are not related by blood as close as would bar marriage.
5. We are domestic partners who are barred from a lawful marriage. (This includes partners of the same sex, or if one or both partners are transgender.)

Subscribers are advised to consult an attorney regarding the possibility that the filing of this declaration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

## Section 3: Signature (required)

By signing this form, we declare that the information we have provided is true, complete, and correct. If it isn't, or if we do not update this information within the timelines in PEBB rules, we must repay any claims paid by our health plan(s) or premiums paid on our behalf. We may also lose PEBB benefits as of the last day of the month we qualified. In addition, we understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of the subscriber's state job.

We understand that:

- Subscribers may add a new spouse or qualified domestic partner within 60 days of marriage or establishment of a qualified domestic partnership, or during a special or annual open enrollment period.
- This declaration shall be terminated upon death of the spouse or qualified domestic partner, or by change of circumstance attested to in this declaration.
- Employees agree to notify their personnel, payroll, or benefits office, and retirees and self-pay members agree to notify the PEBB Program at 1-800-200-1004 if there is any change in the marriage or domestic partnership within 60 days of the change.

**HCA's Privacy Notice:** We will keep your information private as allowed by law.

To see our Privacy Notice, call 360-923-2822 or go to [www.hca.wa.gov](http://www.hca.wa.gov).

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse or Qualified Domestic Partner's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

Agency  
use only

Agency

Subagency

# Declaration of Tax Status

I, \_\_\_\_\_, have completed a *Declaration of Marriage or Qualified Domestic Partnership*  
Print Subscriber's Name  
form or have registered my same-sex domestic partner with the Washington Secretary of State's Office and have sworn  
that \_\_\_\_\_ is my qualified domestic partner.  
Print Qualified Domestic Partner's Name

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a domestic partner is considered an Internal Revenue Code (IRC) Section 152 dependent **only if each** of the following requirements is met (does **not** affect your domestic partner's eligibility for PEBB coverage):

1. The domestic partner and I live together (share our principal abode) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education. In other words, my domestic partner and I must live together from January 1 through December 31.
2. The domestic partner is a citizen or resident of the United States.
3. The domestic partner receives more than half of his or her support from me. The rules for determining support are complicated and are more involved than just determining who is the "primary breadwinner." Enclosed is a worksheet similar to one the Internal Revenue Service (IRS) includes in its Publication 17 that you can use to determine whether you provide, or expect to provide, more than half of your domestic partner's support.

### Please note:

Even if the above requirements are met, an individual cannot be considered an IRC Section 152 dependent if the relationship violates local law.

Check one of the following boxes; **coverage is only available** if you check a box. Even if you check "no" below, your domestic partner still qualifies for PEBB coverage if he or she meets the five criteria for a domestic partnership. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances. I declare that:

- ☐ **Yes**, my domestic partner **is**, or is reasonably expected to be, my Internal Revenue Code Section 152 dependent for the 20\_\_ calendar year.
- ☐ **No**, my domestic partner is **not**, or is not expected to be, my Internal Revenue Code Section 152 dependent for the 20\_\_ calendar year. As a result, premium contributions for my domestic partner cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.
- ☐ **Yes**, my domestic partner's child(ren) as named below **are**, or are reasonably expected to be, my Internal Revenue Code Section 152 dependent(s) for the 20\_\_ calendar year.  
Child(ren)'s name(s) \_\_\_\_\_
- ☐ **No**, my domestic partner's child(ren) as named below **are not**, or are not expected to be, my Internal Revenue Code Section 152 dependent(s) for the 20\_\_ calendar year. As a result, premium contributions for my domestic partner's eligible family members cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.  
Child(ren)'s name(s) \_\_\_\_\_

### By signing this form:

I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

### I understand that:

- This declaration of responsibility may have legal implications under federal and/or state law.
- A civil action may be brought against me for any losses, including reasonable attorney's fees, if I have made a false statement in this declaration.
- I must notify my personnel, payroll, or benefits office (employees) or the PEBB Program (retirees and self-pay members) if there is a change in the domestic partnership or dependent status within 60 days of the change. *Any change in my family status may directly impact the calculation of my taxable income.*

**HCA's Privacy Notice:** We will keep your information private as allowed by law.

To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.

Subscriber's Signature

Social Security Number

Date